		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037515

Facility Name: Montgomery Place

Address: 5550 S Shore Drive (Number) Chicago (City) 60637 (Zip Code)

County: Cook

Telephone Number: 773-753-4100 **Fax #** 773-752-0056

IDPA ID Number: 363582046001

Date of Initial License for Current Owners: 1/24/92

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 ©(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Deborah Hart **Telephone Number:** 773-753-4098

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Monica Ramirez
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	47	Skilled (SNF)	47	17,202	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,836	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,053	6,981	4,013	14,047	8
9	SNF/PED					9
10	ICF	2,287	11,387	28	13,702	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,340	18,368	4,041	27,749	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.52%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/28/92

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 14 and days of care provided 4,010

Medicare Intermediary Cahaba GBA

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	662,094	55,057	2,826	719,977		719,977	(367,871)	352,106			1
2	Food Purchase		478,240		478,240		478,240	(246,645)	231,595			2
3	Housekeeping	238,776	30,093	9,330	278,199		278,199	(201,978)	76,221			3
4	Laundry	47,494	11,525		59,019		59,019	(3,734)	55,285			4
5	Heat and Other Utilities			337,609	337,609		337,609	(245,111)	92,498			5
6	Maintenance	145,154	27,108	130,467	302,729		302,729	(219,787)	82,942			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,093,518	602,023	480,232	2,175,773		2,175,773	(1,285,126)	890,647			8
	B. Health Care and Programs											
9	Medical Director			32,014	32,014		32,014		32,014			9
10	Nursing and Medical Records	1,505,596	85,679	12,736	1,604,011		1,604,011	(79)	1,603,932			10
10a	Therapy											10a
11	Activities	61,694	2,048	9,614	73,356		73,356		73,356			11
12	Social Services	40,951		169	41,120		41,120		41,120			12
13	Nurse Aide Training											13
14	Program Transportation	43,515	8,062	5,204	56,781		56,781	(14,149)	42,632			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,651,756	95,789	59,737	1,807,282		1,807,282	(14,228)	1,793,054			16
	C. General Administration											
17	Administrative	288,000			288,000		288,000	(100,800)	187,200			17
18	Directors Fees											18
19	Professional Services			304,987	304,987		304,987	(88,316)	216,671			19
20	Dues, Fees, Subscriptions & Promotions			11,695	11,695		11,695	(3,387)	8,308			20
21	Clerical & General Office Expenses	491,158	61,120	125,356	677,634		677,634	(202,996)	474,638			21
22	Employee Benefits & Payroll Taxes			635,534	635,534		635,534	(21,731)	613,803			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,664	9,664		9,664	(9,639)	25			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			387,428	387,428		387,428	(58,114)	329,314			26
27	Other (specify):*	124,780	24,057	408,371	557,208		557,208	(557,208)				27
28	**TOTAL General Administration**	903,938	85,177	1,883,035	2,872,150		2,872,150	(1,042,191)	1,829,959			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,649,212	782,989	2,423,004	6,855,205		6,855,205	(2,341,545)	4,513,660			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Montgomery Place #0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,059,135	1,059,135		1,059,135	(955,190)	103,945			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,217	4,217		4,217	422,924	427,141			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,522	31,522		31,522	(22,886)	8,636			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,094,874	1,094,874		1,094,874	(555,152)	539,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,014	348,599	482,613		482,613		482,613			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			51,058	51,058		51,058		51,058			41
42	Provider Participation Fee			47,014	47,014		47,014		47,014			42
43	Other (specify):*							(47,014)	(47,014)			43
44	**TOTAL Special Cost Centers**		134,014	446,671	580,685		580,685	(47,014)	533,671			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,649,212	917,003	3,964,549	8,530,764		8,530,764	(2,943,711)	5,587,053			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,734)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	1,220,425	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(47,014)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,124)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 1,140,053		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,140,053		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Montgomery Place

ID# 0037515

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Services Revenue	$ (12,662)	21	1
2	Transporation Revenue	(14,149)	14	2
3	Church Home Administration Fee	(18,000)	21	3
4	Travel & Entertainment	(5,810)	24	4
5	Late Fees	(2,865)	21	5
6	Independent Living Marketing (dept 211)	(373,920)	27	6
7	Independent Living Activities (dept 202)	(59,619)	27	7
8	Independent Living Resident Svcs (dept 206)	(94,545)	27	8
9	Medical Record Sales	(79)	10	9
10	liquor purchases	(4,680)	2	10
11	Interest Expense	334,373	32	11
12				12
13	Allocations to Independent Living			13
14	Dietary	(367,871)	1	14
15	Food Purchases	(241,965)	2	15
16	Housekeeping	(201,978)	3	16
17	Laundry		4	17
18	Utilities	(245,111)	5	18
19	Maintenance	(219,787)	6	19
20	Professional Services	(88,316)	19	20
21	Dues/Fee/Subscriptions	(3,387)	20	21
22	Clerical & General	(168,969)	21	22
23	Employee Benefits	(21,731)	22	23
24	Travel & Seminars	(1,116)	24	24
25	Insurance	(58,114)	26	25
26	Interest Expense	(1,131,874)	32	26
27	Rent-Equipment	(22,886)	35	27
28	Depreciation	(955,190)	30	28
29				29
30	Administration allocation	(100,800)	17	30
31	Travel	(2,713)	24	31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,083,764)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(367,871)	0	0	0	0	0	0	0	0	0	0	(367,871)	1
2	Food Purchase	(246,645)	0	0	0	0	0	0	0	0	0	0	(246,645)	2
3	Housekeeping	(201,978)	0	0	0	0	0	0	0	0	0	0	(201,978)	3
4	Laundry	(3,734)	0	0	0	0	0	0	0	0	0	0	(3,734)	4
5	Heat and Other Utilities	(245,111)	0	0	0	0	0	0	0	0	0	0	(245,111)	5
6	Maintenance	(219,787)	0	0	0	0	0	0	0	0	0	0	(219,787)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,285,126)	0	0	0	0	0	0	0	0	0	0	(1,285,126)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(79)	0	0	0	0	0	0	0	0	0	0	(79)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(14,149)	0	0	0	0	0	0	0	0	0	0	(14,149)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(14,228)	0	0	0	0	0	0	0	0	0	0	(14,228)	16
	C. General Administration													
17	Administrative	(100,800)	0	0	0	0	0	0	0	0	0	0	(100,800)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(88,316)	0	0	0	0	0	0	0	0	0	0	(88,316)	19
20	Fees, Subscriptions & Promotions	(3,387)	0	0	0	0	0	0	0	0	0	0	(3,387)	20
21	Clerical & General Office Expenses	(202,996)	0	0	0	0	0	0	0	0	0	0	(202,996)	21
22	Employee Benefits & Payroll Taxes	(21,731)	0	0	0	0	0	0	0	0	0	0	(21,731)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(9,639)	0	0	0	0	0	0	0	0	0	0	(9,639)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(58,114)	0	0	0	0	0	0	0	0	0	0	(58,114)	26
27	Other (specify):*	(557,208)	0	0	0	0	0	0	0	0	0	0	(557,208)	27
28	**TOTAL General Administration**	(1,042,191)	0	0	0	0	0	0	0	0	0	0	(1,042,191)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,341,545)	0	0	0	0	0	0	0	0	0	0	(2,341,545)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Montgomery Place** **#** **0037515** **Report Period Beginning:** **07/01/03** **Ending:** **06/30/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(955,190)	0	0	0	0	0	0	0	0	0	0	(955,190)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	422,924	0	0	0	0	0	0	0	0	0	0	422,924	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(22,886)	0	0	0	0	0	0	0	0	0	0	(22,886)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(555,152)	0	0	0	0	0	0	0	0	0	0	(555,152)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(47,014)	0	0	0	0	0	0	0	0	0	0	(47,014)	43
44	**TOTAL Special Cost Centers**	(47,014)	0	0	0	0	0	0	0	0	0	0	(47,014)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,943,711)	0	0	0	0	0	0	0	0	0	0	(2,943,711)	45

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	meals	169,925		$ 719,977	$	86,823	$ 367,871	1
2	2	Food Purchases	meals	169,925		473,560		86,823	241,965	2
3	3	Housekeeping	sq ft	234,706		278,199		170,401	201,978	3
4	5	Utilites	sq ft	234,706		337,609		170,401	245,111	4
5	6	Maintenance	sq ft	234,706		302,729		170,401	219,787	5
6	19	Professional Services	medicare cost alloc	1,838,034		304,987		532,247	88,316	6
7	20	Dues/Fees/Subscriptions	medicare cost alloc	1,838,034		11,695		532,247	3,387	7
8	21	Clerical & General Office	medicare cost alloc	1,838,034		931,607		532,247	269,769	8
9	22	Employee Benefits	salaries	3,649,212		635,534		124,780	21,731	9
10	24	Travel	medicare cost alloc	1,838,034		3,854		532,247	1,116	10
11	26	Insurance	risk	100		387,428		15	58,114	11
12	32	Interest	sq ft	234,706		1,559,015		170,401	1,131,874	12
13	35	Rent Equipment	sq ft	234,706		31,522		170,401	22,886	13
14		Depreciation	specific identification	1,059,135		1,059,135		955,190	955,190	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,036,851	$		$ 3,829,095	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of Scotland		x	mortgage	$16,667.00	12/20/02	$ 20,000,000	$ 19,699,994	6/30/05	0.0606	$ 1,220,425	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$16,667.00		$ 20,000,000	$ 19,699,994			$ 1,220,425	9
	B. Non-Facility Related*											
10	allocated to IL Pg 8										(1,131,874)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,131,874)	14
15	TOTALS (line 9+line14)						$ 20,000,000	$ 19,699,994			$ 88,551	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ none** **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Montgomery Place **#** 0037515 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ none	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT Deborah Hart, CFO

TELEPHONE 773-753-4100 FAX #: 773-752-0056

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	exempt		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 64,305 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Montgomery Place Retirement Community: 170,401 sq ft - 165 units.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	facility	13,650	1990	$ 653,213	1
2	correct balance			238,212	2
3	TOTALS	13,650		$ 891,425	3

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1992	1992	$ 5,735,741	$		$	$	$ 5,735,741	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13	various			1997	20,111	2,012		2,012		13,623	13
14	various			1998	19,268	1,850		1,850		11,449	14
15	various			1999	40,652	1,422		1,422		6,861	15
16	various			2000	143,621	11,596		11,596		46,214	16
17											17
18											18
19											19
20	Design Line/Window Treatments--1st F			2001	1,107	158	7	158		554	20
21	Paramount Mechanical/HVAC Rehab--			2001	7,899	790	10	790		2,765	21
22	Paramount Mechanical/HVAC Rehab--			2001	943	94	10	94		330	22
23	Nolan/East Boiler			2001	6,825	455	15	455		1,251	23
24	Paramount Mechanical/HVAC Rehab--Ele			2001	341	34	10	34		120	24
25	Paramount Mechanical/HVAC Rehab--A/C			2001	267	27	10	27		93	25
26	Paramount Mechanical/Replace 3-Way M			2001	996	100	10	100		349	26
27	Paramount Mechanical/HVAC Rehab--Eva			2001	289	29	10	29		101	27
28	Paramount Mechanical/HVAC Rehab--			2001	552	55	10	55		193	28
29	Paramount Mechanical/HVAC Rehab--			2001	542	54	10	54		190	29
30	Paramount Mechanical/HVAC Rehab--			2001	229	23	10	23		80	30
31	Paramount Mechanical/HVAC Rehab--			2001	622	62	10	62		218	31
32	Paramount Mechanical/HVAC Rehab--			2001	151	15	10	15		53	32
33	Paramount Mechanical/HAVC Rehab--Boi			2001	167	17	10	17		58	33
34	Applied Controls & Contracting/Conne			2001	521	52	10	52		182	34
35	Paramount Mechanical/HVAC Rehab--Flu			2001	329	33	10	33		115	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Countertop Services/Replaced Kitchen	2001	$ 778	$ 78	10	$ 78	$	$ 272	37
38	Design L/2/3Flr Flooring	2001	4,124	412	10	412		1,409	38
39	Design L/2/3Flr wallcovering	2001	5,516	1,103	5	1,103		3,769	39
40	Design L/1st Flr Offices	2001	2,232	446	5	446		1,525	40
41	Rev 06/30/00 Recl Bldg Main 02/21/01	2001	(1,273)	(127)	10	(127)		(435)	41
42	WARD DOOR/Library Doors	2001	270	18	15	18		60	42
43	WARD DOOR/Back Safety/Security Hlw	2001	2,048	102	20	102		341	43
44	DESIGN LINE/Office Renovation--	2001	90	9	10	9		30	44
45	DESIGN LINE/Office Renovation--	2001	185	18	10	18		62	45
46	DESIGN LINE/Office Renovation--	2001	953	95	10	95		318	46
47	DESIGN LINE/Office Renovation--	2001	34	3	10	3		11	47
48	DESIGN LINE/Office Renovation--	2001	233	23	10	23		78	48
49	Design L/Reception Area Carpet	2001	275	55	5	55		183	49
50	DESIGN LINE/Office Renovation	2001	262	26	10	26		85	50
51	DESIGN LINE/Office Renovation	2001	477	48	10	48		155	51
52	DESIGN LINE/Office Renovation	2001	3,037	304	10	304		987	52
53	DESIGN LINE/Office Renovation	2001	275	27	10	27		89	53
54	DESIGN LINE/Office Renovation	2001	2,737	274	10	274		890	54
55	Murphy Miller/HVAC Renovation	2001	18,886	1,259	15	1,259		12,636	55
56	Design L/Electrical Business Off 118	2001	247	25	10	25		78	56
57	Design L/Light Fixtures 1405/1407	2001	144	14	10	14		46	57
58	Design L/Carpet 1st Flr Off	2001	532	107	5	107		337	58
59	Ward Door/Back Door Safety	2001	201	20	10	20		64	59
60	K & S/Upgrade Sprinkler System	2001	238	16	15	16		50	60
61	K & S/Upgrade Sprinkler System	2001	152	10	15	10		32	61
62	K & S/Upgrade Sprinkler System	2001	238	16	15	16		50	62
63	Murphy & Miller/Install 2 Lines to C	2001	1,640	66	25	66		197	63
64	Design L/First Flr Ding Rm-Wall Cvrg	2001	800	160	5	160		467	64
65	Armorstone, Inc./Resurfacing front e	2001	164	11	15	11		32	65
66	Design Lines/Vinyl Plank	2001	434	87	5	87		246	66
67	Design Lines/Ceiling Tiles	2001	114	23	5	23		65	67
68	Design Line/Cabinets First Floor Din	2001	874	58	15	58		165	68
69	Design Lines/Ceiling Tiles	2001	702	140	5	140		386	69
70	TOTAL (lines 4 thru 69)		$ 6,028,792	$ 23,804		$ 23,804	$	$ 5,845,220	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,028,792	$ 23,804		$ 23,804	$	$ 5,845,220	1
2	Design Lines/Carpeting	2001	764	153	5	153		420	2
3	Design Lines/Dining Room Renovation-	2001	592	118	5	118		325	3
4	Design Lines/Dining Room Ren Tiles	2001	789	158	5	158		434	4
5	Armorstone, Inc./Resurfacing front e	2001	329	33	10	33		90	5
6	Design Lines/Dining Room Renovation-	2001	411	41	10	41		113	6
7	Design Lines/Dining Room Renovation-	2001	2,683	268	10	268		738	7
8	Design Lines/Hooker Casegoods-Dining	2001	129	13	10	13		36	8
9	Design Lines/Dining Room Renovation-	2001	144	10	15	10		26	9
10	Design Lines/Dining Room Renovation-	2001	1,499	75	20	75		206	10
11	Design Lines/Dining Room Renovation-	2001	2,656	133	20	133		365	11
12	Design Lines/Therapy Room Conversion	2001	737	74	10	74		203	12
13	Thatcher Oaks Inc/Recover Existing A	2001	1,589	159	10	159		437	13
14	Design Lines/Cabinets First Floor Di	2001	874	58	15	58		160	14
15	Design L/First Flr Ding Rm SCounterT	2001	3,265	218	15	218		599	15
16	Design Lines/Dining Room Renovation-	2001	789	158	5	158		434	16
17	A & M Plumbing & Sewer/Installing ca	2001	1,849	92	20	92		254	17
18	Design L/Dining Room Renovation-ligh	2001	2,683	134	20	134		369	18
19	Design Lines/Dining Room Renovation-	2001	764	38	20	38		105	19
20	Design Lines/Dining Room Renovation-	2001	144	7	20	7		20	20
21	Design Lines/Dining Room Renovation-	2001	2,656	133	20	133		365	21
22	Design Lines/Dining Room Renovation-	2001	1,607	161	10	161		442	22
23	Airways Systems, Inc/Cleaned Gaylord	2001	270	13	20	13		37	23
24	Design Lines/Dining Room Renovation-	2001	1,499	75	20	75		206	24
25	Design/Dining Room Renovation-carpet	2001	683	137	5	137		376	25
26	A & M Plumbing & Sewer/Installing ca	2001	1,644	82	20	82		226	26
27	Edwards Systems Technology/	2001	485	48	10	48		133	27
28	Design Line/Carpeting/dinng rm	2001	1,282	256	5	256		705	28
29	Dorshy, Hodgson & Partners/Architect	2001	3,836	384	10	384		1,055	29
30	Dorshy, Hodgson & Partners/Architect	2001	176	9	20	9		24	30
31	Yellow Freight Line/	2001	43	4	10	4		12	31
32	Yellow Freight Line/	2001	43	4	10	4		12	32
33	Yellow Freight Line/	2001	41	4	10	4		11	33
34	TOTAL (lines 1 thru 33)		$ 6,065,747	$ 27,054		$ 27,054	$	$ 5,854,158	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,065,747	$ 27,054		$ 27,054	$	$ 5,854,158	1
2	Design Lines/Dining Room Renovation-	2001	789	158	5	158		421	2
3	Design Lines/Cabinets First Floor Di	2001	875	58	15	58		156	3
4	Design Lines/Sprinkler Modification	2001	268	11	25	11		29	4
5	Design Lines/First Floor Dining Room	2001	3,266	218	15	218		581	5
6	Design Lines/Dining Room-Hardware	2001	101	20	5	20		54	6
7	Design Lines/Border Paper	2001	44	9	5	9		23	7
8	Design Lines/Dining Room-Accessories	2001	115	23	5	23		61	8
9	Design Lines/Shipping Charges	2001	282	56	5	56		151	9
10	Design Line/Buffet Water Hook-Up Din	2001	572	57	10	57		153	10
11	Design Lines/Dining Room-Buffet Acce	2001	301	20	15	20		54	11
12	Design Line/Drapery Treatments-First	2001	251	50	5	50		134	12
13	Dorshy, Hodgson & Partners/	2001	486	24	20	24		65	13
14	Design Lines/Dining Room Renovation-	2001	765	38	20	38		99	14
15	Design Lines/Dining Room Renovation-	2001	2,683	134	20	134		347	15
16	Design Lines/Solar Shades-Hair Salon	2001	135	27	5	27		70	16
17	Design Lines/Tempered Glass-Dining L	2001	110	22	5	22		57	17
18	Design Lines/Carpeting-East Room	2002	1,162	232	5	232		581	18
19	Dorshy, Hodgson & Partners/Architect	2002	3,360	168	20	168		420	19
20	Design Lines/Replacement Glass-Dinin	2002	78	8	10	8		20	20
21	Design Lines/Painting-1st Floor Offi	2002	59	12	5	12		30	21
22	Design Lines/Dining Room Renovation-	2002	2,657	133	20	133		332	22
23	Dorshy, Hodgson & Partners/Archituct	2002	787	39	20	39		98	23
24	Design Lines/Dining Room Renovation-	2002	1,499	75	20	75		181	24
25	John J. Urbikas & Associates/Elevato	2002	932	93	10	93		194	25
26	Legat Architects/Life Safety Code	2002	1,460	146	10	146		280	26
27	Design L/Vertical Louvers East Rm	2002	81	16	5	16		30	27
28	Design L/Carpeting 2nd & 3rd Fl. 50%	2002	9,423	1,885	5	1,885		3,455	28
29	Design L/Walcovering HC	2002	7,358	736	10	736		1,349	29
30	ACM Elevator/Svc Contract 10-12/02	2002	1,388	139	10	139		254	30
31	Design L/Shipping Garden Furniture	2002	133	13	10	13		24	31
32	Design L/Carpeting 2nd & 3rd Fl. 50%	2002	9,423	1,885	5	1,885		3,298	32
33	Design L/Walcovering HC	2002	7,358	736	10	736		1,288	33
34	TOTAL (lines 1 thru 33)		$ 6,123,948	$ 34,295		$ 34,295	$	$ 5,868,447	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,123,948	$ 34,295		$ 34,295	$	$ 5,868,447	1
2	Design L/Repair Wall & Ceiling 50%	2002	1,791	179	10	179		299	2
3	Design L/Repair Wall & Ceiling Fnl	2002	1,791	179	10	179		299	3
4	Ward Door/Birch Door	2002	255	17	15	17		28	4
5	Design L/Double Door for New Closet	2002	710	47	15	47		79	5
6	Design L/Sink & Counter/Cabinet	2002	2,932	195	15	195		326	6
7	Design L/Repair & Intall Closet	2002	1,791	119	15	119		199	7
8	Design L/Walcover/borders	2002	2,289	458	5	458		763	8
9	Sherwin Williams/Paint for 2nd Floor	2002	247	49	5	49		82	9
10	Design/Shipping Charges HC	2002	1,492	149	10	149		236	10
11	Design L/Walcover/borders (2)	2002	2,289	458	5	458		725	11
12	Design L/Carpet 2nd Fl (1)	2002	1,586	317	5	317		502	12
13	Design L/Corner Guards (1)	2002	1,500	150	10	150		238	13
14	Design L/Relocate Sprinklers	2002	403	40	10	40		64	14
15	Design L/Installation Cabinet/C Tbl	2002	438	88	5	88		139	15
16	Design L/Carpet Base 2nd Fl (2)	2002	1,586	317	5	317		502	16
17	Design L/Wall Prep Covers 2nd Fl	2003	2,290	458	5	458		687	17
18	Design L/Carpet Base 2nd Last Pymnt	2003	1,588	318	5	318		476	18
19	Design L/Croner Guards 3rd Fl (2)	2003	1,599	160	10	160		240	19
20	Design L/Renovation Wall/Ceiling 3rd	2003	1,791	358	5	358		537	20
21	Design L/Renovation Wall/Ceiling 3rd	2003	1,791	358	5	358		537	21
22	Design L/Wall Prep Covers 3rd Fl	2003	2,289	458	5	458		687	22
23	Design L/Carpet Base 3rd Flr	2003	1,586	317	5	317		476	23
24	Design L/Border Paper 2nd Fl	2003	54	11	5	11		16	24
25	Design L/Sink & Counter/Cabinet	2003	1,704	114	15	114		170	25
26	Design L/Double Door for New Closet	2003	1,192	79	15	79		119	26
27	Xpert Fit/Wall Fixture Diffuser	2003	138	10	13	10		15	27
28	Design L/Door for 1st Flr	2003	55	4	15	4		5	28
29	DESIGN LINES/3RD FLR CORRIDOR PREPAR	2003	2,289	458	5	458		649	29
30	DESIGN LINES/2ND FLR DINING RM WALL	2003	1,990	398	5	398		564	30
31	DESIGN LINES/2ND FLR DINING ROOM INS	2003	1,890	189	10	189		268	31
32	DESIGN LINES/2ND FLR DINING RM CROWN	2003	610	61	10	61		86	32
33	DESIGN LINES/2ND FLR DINING RM REMOV	2003	432	29	15	29		41	33
34	TOTAL (lines 1 thru 33)		$ 6,168,336	$ 40,837		$ 40,837	$	$ 5,878,501	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,168,336	$ 40,837		$ 40,837	$	$ 5,878,501	1
2	DESIGN LINES/3RD FLR WORK SURFACE/SI	2003	1,704	114	15	114		161	2
3	DESIGN LINES/2ND FLR DINING ROOM CON	2003	1,817	121	15	121		172	3
4	DESIGN LINES/3RD FLR CORRIDOR INSTAL	2003	1,586	317	5	317		449	4
5	DESIGN LINES/3RD FLR CORRIDOR INSTAL	2003	1,588	318	5	318		450	5
6	DESIGN LINES/2ND FLR DINING ROOM WAL	2003	1,990	398	5	398		564	6
7	DESIGN LINES/SHIPPING CHARGES	2003	706	141	5	141		200	7
8	DESIGN LINES/3RD FLR CORRIDOR PREPAR	2003	2,290	458	5	458		649	8
9	DESIGN LINES/3RD FLR DEMOLITION/REPA	2003	1,791	179	10	179		254	9
10	DESIGN LINES/3RD FLR CUSTOM WORKSURF	2003	1,704	114	15	114		161	10
11	Design L/Door Guard	2003	93	19	5	19		26	11
12	Design L/ Brich Doors Installation	2003	1,493	100	15	100		141	12
13	Design L/Relocate Springklers	2003	459	46	10	46		65	13
14	Design L/Vinyl Planks	2003	1,891	378	5	378		536	14
15	Design L/Borders/Wallcovering	2003	1,990	398	5	398		564	15
16	Design L/Custom Flr & Cabinet	2003	1,817	182	10	182		257	16
17	Design L/Crown Monlding & Installing	2003	610	61	10	61		86	17
18	Design L/Flooring Dining	2003	2,160	432	5	432		576	18
19	Design L/Lower Level Flr Instal Vnl	2003	395	39	10	39		53	19
20	Design L/Crown Moulding & Install	2003	420	84	5	84		112	20
21	Design L/3rd flr Vinyl Plank	2003	1,890	378	5	378		504	21
22	Design L/Prep of Walls/Instl/Borders	2003	1,991	398	5	398		531	22
23	Design L/Instl Vynil Plank	2003	1,893	379	5	379		505	23
24	Design L/3rd Wallcovering/borders	2003	1,990	398	5	398		531	24
25	Design L/2nd Wallcovering/borders	2003	2,038	408	5	408		543	25
26	Design L/3rd flr revoval of cabinets	2003	432	43	10	43		58	26
27	Design L/3rd Floor & Wall Cabinets	2003	1,817	182	10	182		242	27
28	Design L/2nd Custom Flr/Wall Cabinet	2003	1,818	182	10	182		242	28
29	Design L/3rd Flr Install Vynil Plank	2003	1,890	378	5	378		504	29
30	Design L/Lower Level Flr Border	2003	47	5	10	5		6	30
31	Design L/3rd flr Floor/wall cabinets	2003	1,817	182	10	182		242	31
32	Design L/3rd Wallcover/Border	2003	1,991	398	5	398		498	32
33	Design L/3rd Flr Vynil Plank	2003	1,893	379	5	379		473	33
34	TOTAL (lines 1 thru 33)		$ 6,216,347	$ 48,446		$ 48,446	$	$ 5,888,856	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,216,347	$ 48,446		$ 48,446	$	$ 5,888,856	1
2	Design L/3rd Cons/Instl/flr/cabinet	2003	1,818	182	10	182		227	2
3	Design L/3rd Corridor carpet	2003	95	19	5	19		24	3
4	J J Urbika/Elevator Modernization	2003	1,452	145	10	145		169	4
5	Design L/2 Fl Counter Tops Dining Rm	2003	36	2	15	2		3	5
6	Div. Gralak/East Sidewalk Rep 50%	2003	816	54	15	54		59	6
7	Design L/East Room Vertical Blinds	2003	697	139	5	139		151	7
8	Medline/Wheelchair	2003	211	42	5	42		46	8
9	Otis/Renovation	2003	4,300	430	10	430		466	9
10	Murphy & Miller/Compresor	2003	1,582	97	15	97		97	10
11	Div. Gralak/East Sidewalk Rep Final	2003	816	45	15	45		45	11
12	Sing / Graphics Installed (Entrance)	2003	79	13	5	13		13	12
13	Urbikas & Asso/Elevator (Architects)	2003	548	41	10	41		41	13
14	Murphy & Miller/Ac Compresor	2003	1,984		15			1,984	14
15	Urbikas & Asso/Elevators (Architect)	2003	411	27	10	27		27	15
16	Countertop Svcs 50%depst/1215 & 1002	2003	191	8	15	8		8	16
17	Bear Construcion/Entrance Door	2003	9,563	558	10	558		558	17
18	Murphy-Miller/Smoke Damper	2004	2,363	118	10	118		118	18
19	RAE Coating/Floor Abulance Entrance	2004	337	11	10	11		11	19
20	RAE Coating/Removal flr tiles & prep	2004	674	22	10	22		22	20
21	REA Coating/Flake epoxi coating	2004	208	7	10	7		7	21
22	Otis Elevators/Service Elevator	2004	28,667	717	10	717		717	22
23	Design I/Dept 1for Game Room	2004	653	33	5	33		33	23
24	Murphy & Miller/Steam Humidifier	2004	1,106	18	15	18		18	24
25	Ward Door/Door Instalation	2004	288	7	10	7		7	25
26	Design L 50%/Wallcover Game Room	2004	676	23	5	23		23	26
27	Edward Sys/Smoke Detector	2004	712	6	10	6		6	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,276,630	$ 51,210		$ 51,210	$	$ 5,893,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 218,569	$ 1,658	$ 1,658	$		$ 218,569	71
72	Current Year Purchases	19,816	2,155	2,155		9	2,155	72
73	Fully Depreciated Assets	375,621	47,958	47,958		9	157,625	73
74								74
75	TOTALS	$ 614,006	$ 51,771	$ 51,771	$		$ 378,349	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1999 Ford Windstar Van	2000	$ 4,821	$ 57	$ 57	$	5	$ 3,937	76
77	Facility Use	1999 Ford Bus	1999	10,744	907	907		5	10,744	77
78										78
79										79
80	TOTALS			$ 15,565	$ 964	$ 964	$		$ 14,681	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,797,626	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,945	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 103,945	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,286,766	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Allocation to Independent Living-2003	$ 21,978,237	$ 955,190	$ 4,904,286	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 21,978,237	$ 955,190	$ 4,904,286	91

G. Construction-in-Progress

	Description	Cost	
92	Repositioning Project	$ 151,612	92
93			93
94			94
95		$ 151,612	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 8,636 Description: see attached supplemental schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	none		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 159,489	$		$ 159,489	1
2	Licensed Speech and Language Development Therapist		hrs			10,289			10,289	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			172,665			172,665	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts			96,197			96,197	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Attached						43,973		43,973	13
14	TOTAL			$		$ 438,640	$ 43,973		$ 482,613	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,987,889	$	1
2	Cash-Patient Deposits	12,656		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	545,666		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	105,153		7
8	Accounts Receivable (owners or related parties)	97,809		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,749,173	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	42,500		12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	22,762,949		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,593,379		16
17	Accumulated Depreciation (book methods)	(11,191,052)		17
18	Deferred Charges	151,612		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	700,278		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,313,278	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,062,451	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 422,979	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,656		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	288,443		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Restricted Deposits/Funds	638,963		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,363,041	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,948,326		39
40	Mortgage Payable	20,904,772		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 23,853,098	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 25,216,139	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,153,688)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,062,451	$	48

***(See instructions.)**

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,119,174)	1	
2	Restatements (describe):		2	
3	correction of prior year	221,450	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,897,724)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,744,036	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,744,036	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,153,688)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,806,337	1
2	Discounts and Allowances for all Levels	(929,976)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,876,361	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	739,547	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 739,547	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	12,505	14
15	Telephone, Television and Radio	5,291	15
16	Rental of Facility Space	227,415	16
17	Sale of Drugs	114,789	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,282	19
20	Radiology and X-Ray		20
21	Other Medical Services	304,930	21
22	Laundry	3,734	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 689,946	23
	D. Non-Operating Revenue		
24	Contributions	9,189	24
25	Interest and Other Investment Income***	19,809	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,998	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income - see attached	4,939,954	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,939,954	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,274,806	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,175,773	31
32	Health Care	1,807,282	32
33	General Administration	2,872,150	33
	B. Capital Expense		
34	Ownership	1,094,874	34
	C. Ancillary Expense		
35	Special Cost Centers	533,671	35
36	Provider Participation Fee	47,014	36
	D. Other Expenses (specify):		
37	rounding	6	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,530,770	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,744,036	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,744,036	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,936	2,055	$ 86,919	$ 42.30	1
2	Assistant Director of Nursing	2,168	2,301	65,802	28.60	2
3	Registered Nurses	4,053	4,303	106,007	24.64	3
4	Licensed Practical Nurses	24,191	25,680	515,435	20.07	4
5	Nurse Aides & Orderlies	64,562	68,535	646,667	9.44	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,416	1,503	28,330	18.85	9
10	Activity Assistants	3,858	4,098	33,364	8.14	10
11	Social Service Workers	1,952	2,072	40,951	19.76	11
12	Dietician	1,980	2,102	53,638	25.52	12
13	Food Service Supervisor	2,040	2,165	38,130	17.61	13
14	Head Cook	976	1,036	17,938	17.31	14
15	Cook Helpers/Assistants	16,989	18,035	178,778	9.91	15
16	Dishwashers	7,882	8,368	63,481	7.59	16
17	Maintenance Workers	8,232	8,738	145,154	16.61	17
18	Housekeepers	24,024	25,503	238,776	9.36	18
19	Laundry	4,541	4,821	47,494	9.85	19
20	Administrator	1,784	1,894	84,491	44.61	20
21	Assistant Administrator					21
22	Other Administrative	3,684	3,911	197,660	50.54	22
23	Office Manager					23
24	Clerical	18,069	19,180	353,606	18.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,119	2,249	33,371	14.84	31
32	Other Health Care(specify)					32
33	Other(specify) see supp pg	53,681	56,986	673,220	11.81	33
34	TOTAL (lines 1 - 33)	250,137	265,535	$ 3,649,212 *	$ 13.74	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	32,014	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,050	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	monthly	3,612	11-3	44
45	Social Service Consultant				45
46	Other(specify) accounting		41,970	19-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 78,646		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Monica Ramirez	Administrator	0	$ 85,000
Deborah Hart	CFO	0	98,000
Michael Apa	Executive Director	0	105,000
Allocation to Indp Liv			(100,800)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 187,200

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
see attached detail		304,987
less allocation to Indep Living		(88,316)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 216,671

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,315
Unemployment Compensation Insurance	97,588
FICA Taxes	279,165
Employee Health Insurance	145,912
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Health Spending Acct Admin	892
Employee Appreciation/Relations	9,685
Uniforms - Transporation	473
Life Insurance	1,504
Allocation to Indep Living	(21,731)
TOTAL (agree to Schedule V, line 22, col.8)	$ 613,803

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
see attached	8,308
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,308

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
LSN Safety meeting	25
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/03 Ending: 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes-Naides**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,655** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **no** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **no** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **47,014**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **no** Indicate the amount. $ **offset to IL**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Frost Ruttenber & Rothblatt** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.